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Original Lectures.

LECTURES

ON THE

DIAGNOSIS OF DISEASES OF THE HEART.

DELIVERED AT THE

BELLEVUE HOSPITAL MEDICAL COLLEGE DURING THE PRELIMINARY TERM.

SESSION 1862-63.

BY AUSTIN FLINT, M.D.

PROFESSOR OF THE PRINCIPLES AND PRACTICE OF MEDICINE.

LECTURE VIII.

Retrospective Diagnosis of Pericarditis, or the Signs of Pericardial Adhesions.—Pathological Relations of Pericarditis.—Physical Changes in Endocarditis.—The Diagnosis of Endocarditis Based on the Development of an Organic Endocardial Murmur.—Inorganic Murmur in Endocarditis.—Relations of the Disease to Acute Rheumatism.—Importance of the Diagnosis of Functional Disorder of the Heart.—Varieties of Functional Disorders; the Diagnosis Based on the Exclusion of Organic Lesions.—Combination of Organic Lesions and Functional Disorder.—Symptoms Diagnostic of Functional Disorder.—Conclusion of Course.

GENTLEMEN:—In my last lecture I considered the diagnosis of pericarditis, prior to liquid effusion, during the second stage, or stage of effusion, and during the third stage, or stage of absorption. We may, in some cases, at least, make a retrospective diagnosis of this disease; in other words, we can determine the fact of the past occurrence of pericarditis, during convalescence, or at any period subsequent to recovery. After the removal of the effused liquid, by absorption, the pericardial surfaces come into contact. The surfaces become agglutinated by means of the coagulable lymph with which they are more or less covered. And, after a time, in this intermediate lymph, adventitious tissue is formed, which leads to a permanent vital union. Pericardial adhesions, thus, follow pericarditis, as pleuritic adhesions follow inflammation of the pleura. If these are universal or extensive, their existence may be ascertained, often, if not generally, by physical signs. The retrospective diagnosis is based on the signs denoting adhesions of the pericardium. What are the signs representing this consequence of pericarditis?

The base of the pericardial sac is considerably larger than the pointed extremity of the heart; and as the apex is free, it has, in health, a lateral range of motion corresponding to the greater width of the sac. The apex-beat is found, in health, to move from half an inch to an inch, in changing the position of the body from recumbency on the back to a decubitus on the left side. But if the pericardial surfaces are adherent, there is little or no range of motion, the apex remaining fixed in the same spot in all changes of the position of the body. This is the most reliable of the signs denoting past pericarditis; but it is not positive proof, for physical conditions extrinsic to the pericardial sac may prevent the lateral movements of the apex, such as pleuritic adhesions, etc.* Other evidence consists in permanency of the area of the superficial cardiac space; that is, its remaining the same at the end of the inspiratory, as at the end of the expiratory act. In a normal condition of the organs, the increased expansion of the left lung by the inspiratory act, especially if the act be forced, causes a diminution of the superficial cardiac space, as ascertained by percussion. But after pericarditis, often, if not generally, adhesions take place, not only of the surfaces of pericardium which are in contact, but between the outer surface of the fibrous sac and the parts with which it is in contact. In this way the superficial cardiac space is made permanent, and continues the same in inspiration as in expiration. Other evidence, still, in certain cases, consists in retraction of the intercostal spaces within the præcordia, of the epigastrium, and, sometimes, of the extremity of the sternum, during the heart's systole. These signs will enable us frequently to decide that a patient, at some period before coming under our observation, has had pericarditis. And I may remark, in leaving the subject of pericarditis, that adhesions, even when so universal and complete that the pericardial sac is abolished, have not that serious import which they were supposed to have a few years ago. If uncomplicated with valvular lesions, they may give rise to no appreciable inconvenience for an indefinite period.

A single additional remark respecting the diagnosis of pericarditis. Its pathological relations are to be kept in mind. In the vast majority of the cases in which it is not traumatic, it is developed in connexion with either acute rheumatism or disease of the kidneys. Recollecting this, we should direct our attention to the heart in these diseases, and seek for the diagnostic signs of pericardial inflammation.

I come now to consider the diagnosis of inflammation of the lining membrane of the cavities of the heart, or *endocarditis*. And with reference to this disease, the statement made concerning pericarditis is equally, if not even more applicable, viz. the diagnosis rests upon the evidence furnished by physical exploration. Not only was this disease not discriminated prior to the successful application of auscultation to affections of the heart by the successors of Laennec, but the disease has been discovered within the latter period; its existence was unknown in Laennec's day.

What are the physical changes which belong to endocarditis? The endocardium is analogous in its structure to the serous membranes, and when inflamed there occurs the exudation of lymph, as in serous inflammations. More or less of this lymph is washed away by the currents of blood; but more or less remains adherent to the membrane, and chiefly, to the portions which invest the valvular curtains and segments. The endocardial lining of the cavities of the left side of the heart is the seat of the inflammation in endocarditis occurring after fœtal life, so that the exudation of lymph takes place on the parts which form the mitral and aortic valves. On one or both these valves the lymph collects in the form of bead-like deposits, or vegetations. Probably they increase in size by the addition of coagulated fibrin from the blood contained in the cavity of the left ventricle. These lymph-deposits lay the foundation of the valvular lesions, to which we have already given attention. After the lapse of a greater or less period, cretaceous matter is apt to be deposited; the valves may become contracted, or thickened; they may become adherent to each other, or to adjacent parts; rupture may take place, etc., leading, in the end, to contraction, or insufficiency, or both. Here are several specimens, illustrating the existence of recent vegetations on the aortic and mitral valves, obstructive and regurgitant lesions not having as yet taken place.

A deposit of even a small quantity of lymph at either the mitral or aortic orifice, suffices to give rise to an endocardial or bellows murmur with the first sound of the heart. The diagnosis is based on the presence of a systolic murmur, taken in connexion with the circumstances under which it is developed. The latter qualification is essential. Endocarditis almost invariably occurs in one pathological connexion, viz. in the course of acute articular rheumatism. The diagnosis rests on the production of a murmur during the progress of the disease just named. Endocarditis may possibly occur as a primary or idiopathic affection, but practically I have no knowledge of it, except as a complication of acute rheumatism. What circumstances, then, connected with the production of an endocardial murmur, or murmurs, in the course of acute rheumatism, warrant the diagnosis of endocarditis?

It is not sufficient for the diagnosis that an endocardial murmur is found to exist in a case of rheumatism. The murmur may have existed prior to the rheumatic affection.

* As an effect of pericardial adhesions, in some cases, the apex-beat is not to be felt.

If the patient have had rheumatism before, endocarditis may have occurred with the previous attack, leaving a permanent murmur. For the diagnosis to be positive, the murmur must have originated while the case is under our observation; that is, we must have examined the patient when there was no murmur, and thus determined the fact that the murmur has been developed since the attack of rheumatism. If we have not this evidence of the development of the murmur, we can only judge of the probability of existing endocarditis. And the circumstances bearing on this judgment are:—First, the absence of enlargement of the heart. If the heart be enlarged, it is altogether probable that the murmur was antecedent to the rheumatism. Second, the kind of murmur present. An aortic regurgitant murmur does not belong to endocarditis. This murmur represents organic lesions which may follow but do not accompany endocarditis. The same remark holds good with respect to a mitral direct murmur. This murmur does not belong to endocarditis, but to subsequent lesions. It is certainly rare that a truly mitral regurgitant murmur occurs in endocarditis. The mitral valve is not rendered insufficient by existing inflammation. The murmur of endocarditis is a mitral systolic murmur, but as a rule, a murmur without actual mitral regurgitation. It has its maximum near the apex of the heart; is diffused, more or less, over the body of the organ, but does not extend far without the heart, *i.e.* to the lateral surface of the chest and over the back, as it does when the murmur is due to mitral insufficiency.

The inflammatory deposits in endocarditis occur oftener at the mitral than at the aortic orifice; but they do occur at the latter. Hence, an aortic direct murmur may be developed as a sign of endocarditis. The mitral systolic and aortic direct murmur are not unfrequently combined in cases of rheumatism. This may indicate inflammatory deposits at both orifices; but I have been led to believe that an aortic direct murmur occurs in cases of rheumatism without endocarditis. On careful exploration with Cammann's stethoscope, I have found a murmur either in the aorta, or in the pulmonic artery, or in both, to be the rule in cases of rheumatism. I am disposed to regard these basic murmurs as frequently, if not generally inorganic, *i.e.* due to a blood change. I suspect these murmurs may have led to the opinion, with some clinical observers, that endocarditis is a more frequent complication of rheumatism than it really is. This point needs further clinical study, but at present, to my mind, a newly-developed murmur, to be evidence of endocarditis, must be a mitral or intraventricular murmur.

A murmur due to endocarditis may disappear after the recovery from rheumatism. I have known this to be the case. I suppose that its disappearance is owing to the inflammatory deposits having been completely washed away by the currents of blood. I think, however, that as a rule, the murmur is permanent; and if organic lesions follow at a period more or less remote, new organic murmurs may be added.

As I have already stated, we derive no aid in the diagnosis of endocarditis from the symptoms. The disease, so far as symptoms are concerned, is latent. Hence, it is only within a few years that attention has been directed to it, and its existence known. The basis of the diagnosis is, simply, the development of an organic murmur during the progress of acute rheumatism; the endocarditis may occur at any time during the course of acute articular rheumatism, but usually it occurs during the first week. We look for it oftenest in cases which are most acute. I should mention that, as a rare exception to the rule, it sometimes occurs before the articulations become affected.

I come, lastly, gentlemen, to consider the diagnosis of functional disorder of the heart. And, although this concluding subject will require but a brief consideration, its importance is very great. Functional disorder of the heart is of frequent occurrence. It occasions great anxiety and apprehension. Patients fear they have an organic disease, and that they are liable, at any time, to sudden death. They come to us often in a state of the greatest possible mental distress. Now, if the trouble be simply functional, we can assure them of the absence of all danger, and a positive assurance that the heart is sound will go far towards affording relief, for the functional disorder is generally aggravated and kept up by mental uneasiness and concentrating the attention on the disturbed organ. If the practitioner have confidence in his skill in diagnosis, he can thus be of great service to these patients, and, at the same time, acquire credit for professional knowledge. But if, on the other hand, he lack the ability to decide in such cases, he is led to do one of two things; he either decides, at a venture, that the patient has or has not, organic disease, or he expresses himself in a doubtful, non-committal manner. Whichever course he takes, he incurs risk of doing harm and falling into discredit. If he decide that the patient have not organic disease, perhaps after a few weeks or months it becomes evident he was in error. If he decide that the patient has organic disease, when the trouble is purely functional, the consequence is often most unfortunate. I could cite cases of persons affected only with functional troubles, who had given up all active pursuits and hopes in life, and lived in daily expectancy of sudden death for years, after having been told that they have organic disease and might die suddenly at any moment, by medical advisers. The consequence of giving a doubtful opinion is apt to be equally disastrous, for the patient falls back on his own imagination, or he thinks the physician is satisfied of the existence of organic disease, but refrains from communicating the truth. In short, gentlemen, there is hardly a problem in diagnosis of more importance than to determine whether the disturbed action of the heart does, or does not, involve organic lesions. Before I ask how this is to be determined, let us for a moment consider the varieties of functional disorder of the heart.

It is common to include all kinds of disordered action under the head of *palpitation*, which means, strictly, increased action of the heart. Frequently, the only evidence of disorder is increased action; the organ beats with abnormal force and quickness; the patient is sensible of its abnormal activity; it seems to strike against the chest with violence, and patients sometimes describe a sensation as if the organ had escaped from its proper situation, and had risen to the throat. In some cases, this excessive action of the heart persists for days and weeks; but generally it occurs in paroxysms, with variable intervals, lasting from a few moments to several hours. The action may be simply excessive, but in other respects regular—generally, however, the action is irregular. Frequently the organ acts with great disorder for a few beats and then becomes more regular; when the tumultuous action occurs, it seems to the patient as if some extraordinary and unnatural movements were taking place. In other cases, the action of the organ, from time to time, is arrested for an instant; the beating intermits, and the patient feels at each intermission as if the action might cease entirely. These irregular movements are, in fact, due to a kind of clonic spasm of the muscular walls of the heart.

How are we to determine that the forms of disorder, just briefly sketched, are exclusively functional? The answer to this question is very simple; we are to exclude organic lesions. We make physical exploration with sufficient care to discover the signs of organic lesions if they are present, and if the signs of organic lesions are wanting, we exclude them, and decide that functional disturbance alone exists. We can thus reach a positive diagnosis if we are confident in our ability to recognise the physical signs of organic disease. Let us suppose a patient to present himself with symptoms which have led him to apprehend disease of the heart; and that we proceed to explore with reference to the existence or non-existence of organic lesions. We may direct our attention first, to ascertain whether the heart be, or be not enlarged. We find the apex-beat in the normal situation, the superficial cardiac region not increased, and

the left border of the organ within or at the left nipple. We conclude, then, there is no enlargement. We next, auscultate for murmurs. If no murmurs are present, we decide that valvular lesions do not exist. If there be an aortic direct murmur, we may decide that it is inorganic. We compare the aortic and pulmonic second sound of the heart, and find that their normal relative characters are present. These results show the absence of organic disease. We are sure that the affection is purely functional, and we are warranted in giving the patient positive assurances that his heart is sound and that he is in no danger. A few moments devoted to the exploration is sufficient to enable us to reach this conclusion. It is reached so quickly that I sometimes prolong the exploration unnecessarily, lest the patient should think I had not taken time enough to ascertain all the facts.

There is an important topic connected with the subject of functional disorders of the heart, which I must not pass by. Functional disorder and organic lesions may be combined—I mean that a patient with organic lesions may suffer from functional disorder, not arising from the lesions, but from the same causes which give rise to functional disorder in those whose hearts are sound. For example, anæmia, which so often leads to functional disorder alone, may equally give rise to disorder when it co-exists with organic lesions. Without giving due consideration to the fact, the practitioner may attribute the disturbed action of the heart, where functional di-order and organic lesions are combined, exclusively to the latter, and be led thereby to take a more unfavorable view of the case than the nature and extent of the lesions justify. Practically, it becomes a highly important question in certain cases, how much of the existing disturbance is due to lesions, and how much to superadded functional disorder. We must endeavor to form an opinion on this point by ascertaining as far as we can the amount of danger which the lesions have occasioned, and also taking into account circumstances favorable for the production of functional disorders. As a rule, if the heart be but little enlarged, and the evidence of fatty degeneration of the walls be wanting, the lesions, whatever they may be, should not be expected to occasion much distress.

The symptoms attending functional disorder of the heart, although not sufficiently distinctive for a positive diagnosis, without the results of physical exploration, are, nevertheless, not without considerable significance. Functional disorder causes much more mental uneasiness than organic disease. The difference in the mental state of patients with and without organic disease is striking. Patients with organic disease, generally have not that intense anxiety and apprehension which belong to functional disorder. They receive the announcement of the existence of lesions with equanimity. They are often slow to believe that the heart is affected. On the other hand, persons with no organic disease frequently have such a strong conviction of the existence of disease, that they are not easily persuaded of the fact of its non-existence; and they often ask to be examined repeatedly, being fearful that it has been overlooked; they require the most positive assurances to secure their belief. This difference in the mental state possesses some diagnostic significance.

Again, functional disorder manifests itself generally in paroxysmal disturbance, and in the intervals the patient may be free from all symptoms of disorder. If a patient, at times, be able to take active exercise without any abnormal disturbance of the heart's action or want of breath, the probability is that the paroxysms denote only functional disorder. If the paroxysms occur from mental excitement, or without any obvious cause, and oftener in the night than in the day time, they are more likely to be due to functional disorder than to organic disease. These, and other circumstances are to be considered; but the main reliance in the diagnosis is, on the absence of all the physical signs of lesions, or on the evidence afforded by the signs of lesions which are inadequate to produce the amount of disturbance which is present.

I have now, gentlemen, brought to a close my short course of lectures on the diagnosis of Diseases of the Heart. I do not expect, however, with the conclusion of these lectures, to leave the consideration of this interesting and important province of practical medicine. In pursuing together our clinical studies during the session, we shall continue to consider the diseases of the heart, not only with reference to diagnosis but as regards their morbid anatomy, their pathological relations, their causes, and their management. We shall have abundant opportunities to observe the application, at the bed-side, of the rules which have been laid down in this course of lectures; and, in the cases which baffle our therapeutical resources, I shall test the reliability of our means of diagnosis by placing before you the facts revealed by the scalpel.

Original Communications.

CASE OF ALLEGED DEATH FROM CHLOROFORM.

By ADDISON NILES, MD.,

OF QUINCY, ILLINOIS.

I was called on Tuesday afternoon, June 3, 1862, to attend Mrs. W——, a primipara. This being my first visit I was struck by her bloated appearance, and on examination found the lower limbs œdematous. For two years previous she had been afflicted with frequent and painful micturition, the secretion being scanty. She likewise suffered from headache at times, and habitual costiveness, for which latter difficulty she had been accustomed to take purgatives. In childhood she had scarlet fever, from which she recovered with difficulty, after a dangerous and protracted illness of two months.

The membranes had spontaneously ruptured, and the liquor amnii had discharged before I arrived. The os was not dilated, and the pains were moderate. Some time in the evening they became more aggravating, and she desired to inhale ether, which was administered through Luther's inhaler. In consequence of the large volume of air which the inhaler admits, the desired effect was not produced, and vomiting occurred several times. After some hours, the patient not being brought sufficiently under the influence of the anæsthetic, a mixture of five parts of ether and one part chloroform was substituted, the vomiting then ceased, and the anæsthetic was carried far enough to blunt the sensibility to pain, but did not destroy consciousness.

On Wednesday evening the os dilated sufficiently to admit of artificial delivery. Before undertaking it, she was permitted to pass one hour without the anæsthetic, to observe what progress would be made—but the pains diminished in power after sensibility was restored.

Considering that no hope could be entertained of saving the child by such a delay as would occur if the case were trusted to nature, it was decided to terminate the labor by the forceps. Preparatory to doing so an attempt was made to introduce the catheter, but owing to her extreme irritability it was found impossible for her to control herself sufficiently to submit to the operation. She was put under the influence of chloroform, which was administered by the inhaler. The article used was manufactured by Duncan and Flockhart.

After the forceps were applied, it was soon found that owing to the large and unyielding head, considerable time must elapse before the labor could be terminated. As the pulsation of the fœtal heart could not be detected, a question arose as to the best course to pursue. A consulting physician was called, and a decision made to persevere with the forceps, which accomplished the delivery about ten o'clock P.M., Wednesday, after a labor of about thirty hours. The child was in a state of asphyxia, and all efforts to resuscitate it proved unavailing.

After the labor she expressed herself as having been conscious during the whole time, and remarked she did not hear the baby cry; she rested quietly during the night, except occasionally calling for water, which she drank freely. On Thursday morning she examined the child, observing the hands and feet, said "she looked like her father." Her pulse was natural, but she complained of being tired. In the evening her pulse was considerably excited on; being asked how she did, she gave an unmeaning answer, and during the evening talked deliriously about educating the child, which she previously knew was dead. On Friday morning her pulse was quiet, and she had slept soundly, but was then somewhat delirious. During the day she seemed inclined to sleep, but would arouse when spoken to. She could not be persuaded to take nourishment. Friday evening she requested her lower limbs to be rubbed, and that a wet cloth be placed in her hands, and on her forehead; she was drowsy at night, but would wake at intervals, and make known her wants. About eleven o'clock said she was sick, but did not vomit; she afterwards wished to be turned on her side, and assisted herself in doing so, but afterwards seemed exhausted by the exertion. On Saturday morning she bade one of her friends good-bye as he left for home. During the day she slept most of the time. In the evening her mother said to her she was going home, she replied, "Why do you go?"

On Sunday morning she could be aroused to answer questions, but with difficulty; this was the last time she was known to speak. Monday she appeared unconscious, but would swallow liquid nourishment when placed in her mouth. Monday afternoon she had laborious breathing, and the pulse which had been 80 became 100 in a minute. Blood was observed in the mouth, and the tongue appeared to have been bitten. She had a free discharge of lochia and watery urine.

After many unsuccessful attempts, a specimen of urine was at length obtained, free from an admixture of other fluids. It appeared nearly destitute of saline matter; it was albuminous; on examination with the microscope it was found to contain an abundant deposit of granular epithelial casts and renal epithelium.

On Monday night the breathing became spasmodic—this was increased by the attempt to swallow fluids. Tuesday morning the pupils were dilated, the lips blanched, the countenance cadaverous, and the difficulty of breathing increased; twenty minutes past eleven o'clock death occurred.

Unfortunately no examination of the body was permitted. There can be no reasonable doubt but that the immediate cause of death was effusion in the brain and air cells of the lungs, caused by the poisonous action of urea retained in the blood, in consequence of the failure of the kidneys, from disease, to eliminate it. The non-occurrence of eclampsia during labor is probably due to the prophylactic influence of the anæsthetics. The blood observed in the mouth, and the injury done to the tongue, render it probable that a convulsion did occur at some subsequent time. The value of anæsthetics as a means of arresting or preventing puerperal eclampsia is now so well settled in the minds of the profession, that I feel as if no apology is due from me for using it in this instance.

Yet notwithstanding this, the case just related has been verbally reported by respectable practitioners in this city, as I am credibly informed, as one of death from chloroform, apparently not for the benefit of the profession at large, but to discourage its use in this city. If this report be truthful, it is proper that the first case of death from chloroform, occurring in the hands of medical men in the practice of obstetrics, be placed on record.

Dr. Snow, who wrote in 1858, has given a history of all the recorded deaths from chloroform, which occurred in surgical practice up to that time. It appears that in fifty cases reported, that dangerous symptoms followed speedily by death, occurred within three quarters of an hour after the inhalation commenced. Dr. Sanson presents the history of thirty-four cases which have occurred from the time of the publication of Dr. Snow's work, up to May 4th, 1861. The author combined them, and offers an analysis of the most salient points. Of all the cases only two occurred where a proper inhaler had been used. Of fifty-one cases, thirty-eight declared their danger by sudden stoppage of the pulse. Five deaths occurred in which there was great muscular excitement; collapse immediately following. Sudden vomiting and death occurred twice, congestion of the face was most marked in six, and cessation of breathing in eight. Dr. Sanson concluded that death occurred by syncope, and asphyxia, both of which are necessarily sudden. The author considered that the highest estimate of the number of deaths, to the number of inhalations, bore the proportion of one in two thousand. Others, however, consider this ratio of deaths to the inhalations, as greater than the facts will warrant.

I have referred to the history of twelve cases of death from chloroform in surgery, which have occurred since Dr. Sanson's cases were published; in all, death occurred in a few minutes after the inhalation commenced, from cardiac syncope. Practitioners in this city have had but little experience in the use of anæsthetics in obstetrics, and will doubtless be glad to be favored by the opinions of their brethren in New York, on the merits of the question, whether death in this case was, or was not, caused by chloroform. Besides, it is a question in which the profession at large is interested.

REMARKS ON ALBUMINURIA,

MADE BEFORE THE NEW YORK ACADEMY OF MEDICINE.

By AUSTIN FLINT, M.D.,

PROF. OF THE PRINCIPLES AND PRACTICE OF MEDICINE.

(*Concluded from* p. 300.)

I PASS to another question. The morbid appearances of diseased organs are only effects of disease. They denote results of morbid processes. Now, what morbid process or processes underlie the appreciable pathological conditions of the kidneys? According to Christison and Frerichs, the underlying process is congestion of the kidneys. Prof. Clark favors this view. As a speculative question—and the question is of necessity speculative—I am disposed to doubt the sufficiency of mere congestion to induce the various changes, although it is probably sufficient to give rise to albumen in the urine. We cannot, of course, have positive proof that congestion has preceded the morbid conditions which we discover after death; nor can we say when we find the kidneys merely congested, that had the patient lived, and this congestion persisted, it would have eventuated in any of the morbid conditions of Bright's disease. Evidence to my mind of the insufficiency of mere congestion is afforded by the following fact: Disease of the kidneys does not occur as a rule, when congestion of them must exist, and continue for a greater or less period, viz. in cases of cardiac valvular lesions with dilatation of the cavities on the right side of the heart. This statement may seem surprising to some whom I address. I shall presently refer to the grounds for the correctness of the statement.

Johnson and others consider acute albuminuria as consisting in inflammation of the lining membrane of the convoluted tubes. Johnson styles this disease *acute desquamative nephritis.* He regards it as a kind of catarrhal inflammation, characterized by the exfoliation of epithelium and exudation of lymph; and the casts in the sediment of the urine composed of these morbid products is to this inflammation, what the expectoration is to the bronchitis. Indeed, I think it is Barlow who calls this disease by a title which involves a solecism, but nevertheless is significant, viz. *renal bronchitis.*

So, in chronic albuminuria with atrophied kidney, Johnson considers the morbid process inflammation, the disease taking as its point of departure the lining membrane of the tubes; the inflammation being subacute and chronic; and

leading, after a time, to disintegration and destruction of the secreting tissue. These views seem to me reasonable.

With regard to the chronic disease, characterized by the presence of morbid deposits which remain and produce enlargement of the kidneys, we must wait for further light, rendering clear the character and point of departure of the underlying processes.

The idea has been suggested that morbid reflex influences, involving the ganglionary nervous system, are concerned in the production of the morbid conditions of the kidneys. This throws us back on the sufficiency of congestion; for the morbid influences supposed to be transmitted from some other local affection, are thought to produce congestion by paralysing the forces carrying on the circulation within the kidneys. It may be added that, in the great majority of the cases of albuminuria, there are no obvious antecedent local affections of other parts sustaining relations to the kidneys through the ganglionary system.

The pathology of albuminuria probably extends further backward, or deeper, than the kidney affections. Morbid conditions of a more general nature are involved. When an affection of the kidneys complicates or follows scarlatina, with our present humoral views, we suppose there is a special poison in the blood which acts upon the renal organs. There are grounds for supposing antecedent blood-changes in other cases. Perhaps this is sufficiently shown in all cases by a fact which seems to me not to have been sufficiently dwelt upon. I refer to the law of parallelism as applied to the morbid condition of the kidneys. Albuminuria in its different forms belongs among the symmetrical diseases. Both renal organs are affected in a similar manner, and in about the same degree. This fact certainly holds good in the vast majority of cases. If one kidney be enlarged, the other is enlarged likewise, and so with respect to atrophy. We did not find one organ enlarged and the other atrophied. The enlargement, or the atrophy, is usually equal in the two organs. If one kidney be fatty, so is the other, etc. This law of parallelism is generally considered as, in itself, sufficient proof of the dependence of local affections on antecedent blood-changes. And as regards our ignorance of the nature of the antecedent blood-changes in albuminuria, we are not more in the dark than with respect to other affections, for example, tuberculosis, in which their existence is considered as logically proved. In pulmonary tuberculosis, too, as in albuminuria, the general morbid condition may not reveal itself by any appreciable morbid phenomena prior to the development of the local affection.

I come now to a branch of the pathology in which our knowledge appears to be somewhat more complete and satisfactory, viz. the relations of the symptomatic events belonging to the clinical history of albuminuria, to the immediate pathological effects of the morbid conditions of the kidneys. Taking, as a clue, the excretion of albumen incidental to interference with the circulation in the kidneys, and the non-elimination of urea incident to interference with the secretory function of the kidneys, we are guided through much of the labyrinth of the clinical history.

First, let us consider the relation of the excretion of albumen to dropsy, that symptomatic event which is so frequent in cases of albuminuria. The loss of albumen diminishes the density of the blood. The specific gravity of the blood-serum has been known to fall from 1.030, the normal standard, to 1.010. We can understand that this effect upon the blood favors dropsical effusion. Moreover, the loss of albumen impedes the capillary circulation, and thus leads to congestion. Majendie, many years ago, showed that the *viscosity* of the blood, due to its fibrin and albumen, was necessary to its free circulation. We can understand that dropsy may, in part, arise from the impaired viscosity of the blood. Again, in some cases of albuminuria the amount of water eliminated through the kidneys is much diminished. We can understand that the accumulation of water in the blood (Hydræmia) may conduce to the occurrence of dropsy. The dropsy, *ceteris paribus*, is generally found to be in proportion to the abundance of the albumen in the urine, and the duration of the albuminuria. The invariable occurrence of dropsy in acute albuminuria, and in chronic albuminuria with the large kidney, is explained by the interference with the circulation in the renal organs in these diseases; and, on the other hand, the lesser amount of dropsy, and the occasional absence of this event, in chronic albuminuria with the small kidney, are explained by the fact that, in this disease, the interference is not so much with the circulation as with the secretory function of the kidneys.

The loss of albumen, in the second place, accounts for the anæmia which is so common an event in the clinical history of acute albuminuria and chronic albuminuria with the large kidney. While it is still a problem in physiology when and how the red corpuscles of the blood are produced, this is certain: they depend upon a normal quantity of albumen of the blood. And if the albumen of the blood be diminished by disease, the red corpuscles decrease, and anæmia is accordingly a result. The anæmia in cases of albuminuria, *ceteris paribus*, is in proportion to the amount of loss in albumen which the blood sustains in consequence of its excretion in the urine. The loss of albumen, in fact, accounts for the fatal result in those cases in which death occurs purely from asthenia, without any manifestations of uræmic poisoning.

The relations of retention of urea are not less intelligible. We have, first, vomiting and purging, as events in the clinical history, arising from the effort of nature to eliminate the urea vicariously through the mucous membrane of the alimentary canal. The experiments of Bernard and Barneswill have shown that, when the kidneys are removed in inferior animals, the urea, accumulating in the blood, finds its way, for a time, into the alimentary canal, being generally converted, after its elimination, into the carbonate of ammonia, but sometimes found unchanged in the intestines. The vomiting and purging which occur in cases of albuminuria, are, therefore, conservative, a fact of much importance in its bearing on therapeutics.

Next, certain intercurrent inflammations are attributable to the accumulation of urea in the blood. Inflammations of serous structures, more especially peritonitis, pleuritis, pericarditis, occur in the course of albuminuria sufficiently often to show a pathological connexion; they occur oftenest in chronic albuminuria with small kidney, but not unfrequently in acute albuminuria, and it is fair to attribute their occurrence to the action of urea. The neuralgic pains which are apt to occur in cases of albuminuria, probably have the same origin.

Lastly, the convulsions and coma which in a certain proportion of cases bring to a fatal termination the diseases included under the name of albuminuria, proceed from uræmic poisoning. Fatal uræmia occurs in each of the three diseases, but it occurs by far most frequently in chronic albuminuria with the small kidney. And as cases of chronic albuminuria with the large kidney sometimes end fatally by asthenia without any manifestations of uræmia, so cases of chronic albuminuria with the small kidney sometimes end fatally without any of the phenomena dependent on the excretion of albumen, and even without the presence of albumen in the urine.

My remarks on the causation of albuminuria, Mr. President, will be brief.

In acute albuminuria a special poison in the blood is supposed to exist. Analogy might suggest the probable existence of a special morbific agent in other cases. But as bronchitis, in its epidemic form (influenza), is due to a special cause, and as it ordinarily occurs is supposed to be produced by ordinary causes, the same may be true of this disease. I have not had time to analyse cases with respect to the point, but my impression is that acute albuminuria, when not connected with scarlatina, is apt to follow some unusual exposure to cold.

Chronic albuminuria we have seen to be slow and insidious in its development. Probably, in general, when cases

first come under the cognisance of the physician, albumen in the urine has already existed for months or even years. The causes, whatever they may be, are gradual in their operation.

Clinical facts do not appear to show connexion with any antecedent, appreciable local affections of other parts than the kidney, which may be suspected of sustaining a causative relation to the pathological conditions in albuminuria.

There does not seem to be ground for supposing that a hereditary influence is involved in the causation.

As regards the influence of age, an analysis of fifty-two cases of albuminuria which I have recorded (exclusive of cases connected with scarlatina), gives the following results:—Under ten years of age, no cases; but the majority of cases analysed were in hospital practice, and patients under ten are rarely admitted into hospitals. Over ten and under twenty, three cases; over twenty and under thirty, twenty-one cases; over thirty and under forty, fourteen cases; over forty and under fifty, nine cases; over fifty and under sixty, three cases; over sixty and under seventy, two cases; over seventy, no cases. These results show diminished liability to albuminuria as the two extremes of life are approached. The greatest liability is between the ages of twenty and forty.

As regards sex, of fifty-seven cases, forty-four were males and thirteen females. Some of my cases were collected when I was attending exclusively male hospital wards, and some when attending exclusively female wards. Undoubtedly, males are much more liable to become affected with albuminuria than females.

An interesting point of inquiry relates to habits as regards the use of alcoholic drinks. In the analysis of my cases, with respect to this point, I have separated the hospital cases from those observed in private practice. The habits were noted in the histories of twenty-seven hospital cases. Of these twenty-seven cases, in two only were the habits strictly temperate; but we all know how rare it is to find patients in a public hospital who are perfectly temperate. Of the remaining twenty-five cases, seven were hard spirit drinkers, three were beer drinkers, and five drank moderately or only occasionally. Of cases in private practice, the habits were noted in ten. Of these ten cases, in nine the habits were temperate; one patient only was intemperate. In saying that the habits were temperate in these cases, I mean that the patients were not habitual drinkers, nor accustomed to occasional excesses, that all were absolutely teetotallers. The facts just stated go to show that albuminuria is not *par excellence* induced by intemperance. Goodfellow's opinion respecting the dependence of the contracted kidney on the use of alcoholic drinks, is certainly not tenable. To support his opinion he is obliged, in one of his cases, to attribute the production of the disease to the inhalation of the vapor of spirit. A case has very recently come under my observation, in which, as judged by the symptoms, there existed the contracted kidney, the patient having since died with uræmic poisoning, and this patient, a man over fifty years of age, had always been perfectly temperate.

I have never observed the association of gout and the contracted kidney. Dr. Todd, as is known, attributed to the two diseases a pathological connexion, and styled the contracted kidney the gouty kidney.

I come, lastly, to speak of the co-existence of albuminuria and cardiac disease. There has been considerable discussion as to whether the pathological conditions of the kidney give rise to valvular lesions and enlargement of the heart, or *vice versâ*. I have been led to think that the two are not associated sufficiently often to show any pathological connexion between them, or, at all events, that disease of the heart very rarely, if ever, stands in a causative relation to the pathological conditions of the kidneys included under the name of albuminuria. I would premise that it is not enough for some deviation from the size of the heart to exist, or some abnormal condition of the valves, to show a causative influence. Simple hypertrophy, if not excessive, alone does not occasion notable trouble; so valvular lesions may be innocuous. I think it should be assumed that, for cardiac disease to exist sufficiently to be suspected of giving rise to disease of the kidneys, there must be sufficient dilatation, either with or without valvular lesions, weakening the organ, more especially the right cavities, and thus inducing more or less general congestion. Statistics will, I believe, show that in grave cases of diseases of the heart, albuminuria rarely exists save as an incidental symptom, not as representing the pathological conditions of the kidney to which the name of albuminuria is applied. This opinion is based on an examination of a large number of cases while I was engaged in preparing my work on diseases of the heart. Again, cases of albuminuria afford the signs of important cardiac disease during life, and the appearances after death in a small proportion of cases.

Of twenty recorded hospital cases, which were not fatal under my observation, there were no signs of disease of the heart in seventeen; signs of valvular lesions, with more or less enlargement, were present in only three cases. With reference to the adequateness of physical signs in determining the existence of disease of the heart, we may certainly assume that they suffice to show with positiveness disease of importance enough to be suspected of inducing disease of the kidney.

Of fourteen hospital cases proving fatal, and the autopsies recorded, there was no cardiac disease in seven; in two cases recent pericarditis existed; and in five cases there were valvular lesions with more or less enlargement. It is worthy of note that in four of these five cases the valvular lesions were aortic, for it is well known that aortic lesions are less apt than mitral to lead to dilatation of the right cavities.

Of ten cases in private practice, not fatal, there were no signs of valvular lesions or enlargement in nine. In one case there existed mitral lesions and hypertrophy. In two cases there was recent pericarditis.

Assuming that cardiac disease, in order to give rise to disease of the kidneys, must have advanced far enough to occasion marked disturbance of the circulation, these facts furnish very little ground for supposing any causative connexion.

In the one hundred cases of albuminuria reported by Bright, cardiac disease co-existed in forty-nine. But of these forty-nine, only eight had valvular lesions with enlargement. The remainder had simple hypertrophy, or the heart was considered somewhat large, or valvular lesions existed without enlargement. It seems to me that, with reference to the suspicion of causation derived from pre-existing cardiac disease, all the cases, save eight, are to be excluded.

In the thirty cases reported to this Academy by Prof. Clark, cardiac disease existed in only three. In one of these three cases, the lesions were those of old pericarditis with enlargement, and in another of these cases there was simple hypertrophy.

In conclusion, Mr. President, incomplete as is our present knowledge of the subject under discussion, it is interesting to consider how much light has been shed on morbid phenomena by the discovery of Bright. Prior to the researches following his discovery, in cases of general dropsy dependent on albuminuria, physicians were content to say that there was either excess of exhalation or deficiency of absorption; the significance of the vomiting and purging now attributed to the vicarious elimination of urea, was not understood; the sources of the intercurrent inflammations were unknown; the uræmic convulsions were attributed merely to cerebral irritation or to inflammation of the brain; and sudden fatal coma was considered as due to simple apoplexy. So, as we may hope, equally important discoveries are hereafter to be made, opening new fields of research, and illuminating portions of the great field of pathology which are now shrouded in darkness.

AMPUTATION OF THE ANKLE-JOINT.

By E. P. BENNET, M.D.

DANBURY, CONN.

The want of success which often attends this operation, is dependent in most cases upon an accumulation of fluids in the cup-like flap which prevents union by the first intention, and often leads to ulceration, prolonging the cure and producing a bad stump. All this trouble can be remedied by doing exactly what authors are particular in saying you must not do, that is, by making an incision through the flap at its posterior part, and thus obtaining proper drainage. I usually put into this incision a dossil of lint to prevent its closing up, and in this way obtain a speedy cure and an excellent stump. Performed in this manner, I think it preferable to Pirogoff's operation, especially in military surgery, for in the latter operation the cure is not so rapid or so certain, as the bones may not unite kindly, and may become carious or necrosed. The slight difference in length can be easily remedied by a thicker sole of the shoe.

Danbury, Conn., Nov. 21, 1862.

Reports of Hospitals.

A CASE OF GANGRENE OF THE THROAT,

OCCURRING IN THE HOSPITAL AT FORT HAMILTON, N. Y.

By W. H. STUDLEY, M.D.

ACTING ASSISTANT SURGEON, U.S.A.

In a recent issue of the Medical Times an interesting article appears, describing a peculiar disease which the writer terms "*Gangrene of the Throat.*" Within a short time, a case of sickness, resulting in death, occurred in hospital at this post, bearing in some respects so close a resemblance, that it may not be altogether unprofitable to give it publicity.

Charles Perkins, aged 21, born in New York state, and enlisted as a soldier since August last, appeared on the sick list towards the last of October. His symptoms were those of common remittent fever, and he was treated in the usual manner for such. The treatment met with no favorable response. The disease soon assumed the form, more or less, of continued fever, and at last put on the more striking characteristics of genuine typhus: dry, blackish-brown tongue, teeth covered with sordes, persistent stupor, inability or disinclination to answer questions, more or less confined bowels, absence of tympanitis, and the characteristic dark spots of the skin. In this stage of the disease, he was put upon quinine, brandy, and chlorate of potash, and supported with beef-tea, egg-nog, etc. Within the short space of four or five days, all the worst symptoms disappeared. The patient began to call for food, conversed freely, and even, though unadvisedly, sat up. He continued to improve for a few days, when one morning he complained of a little soreness of the throat. It being damp weather, and the windows having been left open by the attendants longer than they should have been, the inference was that it was the effect of exposure to the cold damp air. Slight fever and considerable debility now supervened, with loss of appetite. He kept his bed, and gave evidence of a general relapse. But little was done for his throat for the reason that it was lightly complained of, but for the more serious constitutional symptoms the former supporting treatment was again resorted to. Within three days of his first complaint of his throat, I found him in my morning visitation breathing very laboriously, like one with croup, every inspiration giving a loud noise similar to that produced in hooping-cough paroxysm, and hawking up freely a stringy, viscid mucus. His pulse was now considerably quicker and fuller than natural, and he wore an anxious countenance. I got him up in a chair, and with a tongue spatula explored the fauces, found the left tonsil a little swollen, and just anterior to and below it, a bulging, semi-transparent bag. I introduced a sharp pointed bistoury, and made several cuts which were followed by slight bleeding. I then passed my finger down the throat, found the epiglottis very œdematous, as also the parts above the vocal chords. I then, for want of a better instrument, took a common gum lancet, and first passing the index finger of my right hand down to and over the epiglottis, with my left passed the lancet down flatwise as far as I could, and then turning it and flexing the handle, was enabled to reach the diseased parts, in which I made about six or eight gashes. Pretty free bleeding followed, with some vomiting produced by the gagging operation, and in a few minutes the patient expressed himself greatly relieved.

I then ordered the following:—℞ Ammoniæ muriatis ʒ ss.; potassæ chloratis ʒ ss.; acaciæ gum. ʒ j.; Syrupis simplicis ʒ iv.; aquæ ʒ xij.; Misce.

S. One tablespoonful every half hour.

I visited him during the evening of the same day and found him quite comfortable, so far as his breathing was concerned, though a hurried pulse, quick breathing, and a disposition to toss about in bed, indicated mischief somewhere. Next morning, about four o'clock, he expired—whether from exhaustion or suffocation I was unable to determine, from the imperfect account given by the attendants.

Autopsy thirty hours after death. None of the abdominal or thoracic viscera gave evidence of lesion. There was none in the œsophagus or trachea. But on opening the larynx, the parts on its left, beginning with the ventricle and including it, embracing the whole arytæno-epiglottidean fold, the left side and top of the epiglottis, and a narrow strip of mucous membrane, extending up to the left tonsil, presented a blackish green swollen mass. Cutting into it in several places, revealed this discoloration to the depth of one-fourth to one-third of an inch. There appeared no ulceration, but on the contrary, the mucous membrane seemed entire, with the exception of the cuts made by the gum-lancet.

With this description of the case, I leave it for each one to name the disease according to his fancy.

Reports of Societies.

NEW YORK ACADEMY OF MEDICINE.

Adjourned Meeting, July 9, 1862.

DR. JAMES ANDERSON, PRESIDENT, IN THE CHAIR.

DISCUSSION OF DR. BYRNE'S PAPER ON PELVIC HÆMATOCELE.

(Dr. Byrne's Remarks, Concluded from page 303.)

As regards retroversion of the uterus, the remarks of Dr. Barker being, in substance, those which may be found in my paper, I need only repeat what has there been stated, viz. that "Retroversion *at first sight* might be mistaken for hæmatocele, or *vice versâ*, but the position, or rather direction, of the os and cervix, and other features diagnostic of this displacement, render it hardly possible to entertain doubts on this point after mature reflection: should some peculiarities be present, however, tending to excite suspicions one way or other, the introduction of Simpson's sound will be the most unequivocal means of arriving at a correct inference."

So also in reference to dislocated ovarian cysts and fibrous tumors—more particularly the latter, which, contrary to the statement of Dr. Barker, might, I imagine, under certain circumstances, be very readily mistaken for hæmatocele. Very clever diagnosticians *have* made such mistakes, and therefore to ignore this difficulty would be acting contrary to facts and experience, and unsafe in practice. In the case related by Dr. Barker as having occurred in Bellevue Hospital, there is one statement which requires

some explanation, and that is where he says, "*In introducing my finger into the rectum, I could lift up the tumor, and carry it forward without any great appearance of distress, which would not be the case in pelvic cellulitis.*" Now of hæmatocele I would remark, that if there be one symptom more characteristic than another of this particular kind of tumor, it is *its total immobility;* because, even when the hæmorrhage takes place *into* the recto-uterine *cul de sac*, there has never, I think, been an instance in which a *firm* tumor was recognised until the peritonæal inflammation had isolated the effused mass by forming an upper boundary for the cyst, when the swelling is found to be firmly fixed to the adjacent parts; and, on the other hand, when the blood happens to be outside or under the serous membrane, the tumor is immediately formed, and equally immovable. I shall therefore look forward with some interest to Dr. Barker's promised report of that case.

In the other case related by Dr. Barker as having occurred at Astoria, it has been stated that "*there were symptoms of hæmatocele.*" The patient, it appears, "was taken, after using an injection of cold water, with intense peritonæal pain, tympanitis, a sudden but not very profuse discharge of blood, and excessive collapse." There was great difficulty in passing water and evacuating the bowels, and a tumor was formed in the pelvic cavity—how long after it is not stated—"and after the lapse of some months a discharge of pus took place." Pelvic cellulitis, though a rare disease when unassociated with the puerperal state, yet does sometimes occur, or at least a condition of things very similar; and just such a case as Dr. Barker describes, I have met with in a married lady who had never been pregnant. This patient had been troubled with leucorrhœa, for which syringing with cold water was prescribed. While in the act of carrying out this part of the treatment, she was seized with symptoms precisely similar to those noticed in Dr. Barker's case, and after nine or ten weeks was relieved by a copious discharge of pus through the rectum. Now I never should suspect such cases to be examples of hæmatocele, and I cannot, therefore, view the diagnosis in the one related by Dr. Barker as correct.

As to the relative frequency of the two admitted varieties of hæmatocele, it has been asserted that the intra-peritonæal is by far the more frequent, even "as three to one." I cannot possibly understand by what process of reasoning gentlemen manage to arrive at such a conclusion, and, though ever since the appearance of the memoirs of Bernutz, one writer has followed another in reiterating this opinion, I must here protest against the acceptance of such inferences, however stereotyped, for I think they are both rash and illogical, and calculated to lead us astray in our pursuit of the correct nature of this disease. The fallacy of basing such statements on the post-mortem statistics of hæmatocele is too apparent to need more than a simple denial of the right to be guided by this kind of evidence; because, in the first place, intra-peritonæal hæmorrhages, if at all excessive, must necessarily be fatal in the great majority of instances, and, secondly, in cases where the mischievous and unjustifiable tampering with human life, usually called "*the expectant treatment*," has been adopted, as for instance in Case 32, and others related by Voisin, I cannot see how it is possible, where the whole pelvic organs are matted together by adhesions, to arrive at any degree of certainty as to the origin and exact relative location of the effused blood. Since my paper was submitted to this Academy, I have continued to investigate the various points relating to the pathology and diagnosis of these affections, and in the chapter commencing at page 37 of my "Researches," lately published, I have endeavored to present my views in as plain and condensed a manner as possible; consequently, for the sake of brevity, I will crave your attention while I read what has been there stated. . . . . .

"One of the arguments adduced by those who question the existence of large hæmatomas within the cellular tissue, and founded, no doubt, upon ideas such as that promulgated by M. Lefort,* is, that if not impossible, it is at least very improbable, that the peritonæum could be so raised up from the uterus as to form the upper boundary of the cyst. It is true, though the post-uterine cellular tissue near the cervix and upwards to the extent of an inch, and sometimes more, is loose and abundant, it gradually becomes less so from this point, more dense, and, towards the fundus, semi-fibrous. It must also be admitted, and I have satisfied myself as to the fact, that, in this latter situation, the serous tunic cannot be separated, *with any degree of facility*, from the uterine stroma, unless the parts have first been subjected to maceration.

"However, those who initiate their arguments from a mere anatomical point of view, and without making due allowance for the relative as well as the structural changes which diseased action may produce in these and other parts, ought to bear in mind that it is very probable these tissues often undergo as complete maceration when subjected to certain pathological influences in the living body (as for instance in pelvic cellulitis, or that condition which Pirogoff would term acute purulent œdema), as they do when removed from the dead subject and submitted to the action of fluids with this special aim.

"Indeed, Professor Simpson, who treats this whole subject in his usual lucid and eminently practical style, has conclusively settled this question by the following facts: A patient 'was sent from a great distance to Edinburgh, in consequence of a pelvic tumor having suddenly appeared. Fatal inflammation was set up by the journey. On dissection I found the reflection of the peritonæum between the uterus and rectum raised up, and a large mass of broken coagula of blood formed the tumor, having been extravasated behind the peritonæum, forming the posterior covering of the broad ligament, and, as it accumulated, having separated and pushed before it that portion of peritonæum and utero-rectal fold of this membrane.' Those who will take the trouble to carefully analyse the record of cases thus far available, cannot fail to be impressed with two very important facts noticeable in most of them, namely (first), the absence of symptoms sufficiently indicative of so grave an accident as extensive hæmorrhage into the peritonæal sac, and (second), *the lateral position of the tumor* above the brim of the pelvis, and frequently also in the vagina.

"These two peculiarities alone, or, in fact, either one, ought (I imagine) to make any diagnostician, however expert, hesitate in pronouncing such tumors intra-peritonæal: because there is surely nothing in the normal arrangement of the pelvic viscera, nor is there any pathological law regulating the disposition of fibrinous adhesions following acute peritonitis which would favor, so often, this lateral isolation of the blood. Besides, is it at all probable that resorption of such large masses of blood, or, indeed, recovery through any means, would result so frequently, if we admit that the serous membrane is often the seat of such violence? Consequently, that *encysted bloody tumors within the peritonæal cul de sac are extremely rare*, and that *those occupying the structures external to that membrane constitute the great majority*,—say 75 or 80 per cent. of the whole,—would seem to be about the correct conclusion to arrive at, regarding the relative frequency of intra and sub-peritonæal hæmatocele.

"These opinions, thus confidently expressed, and no less positively entertained for some time, have lately induced me to pursue my investigations further, with a view, if possible, of being able to correct certain misconceptions which exist respecting the differential diagnosis of these '*intra-pelvian sanguineous cysts.*'—(Tilt.)

"It has been repeatedly asserted by many who might be considered capable of offering an opinion on these points, that in sub-peritonæal hæmatocele, the tumor in

* Voisin, page 215.

the vagina will be lateral, and the uterus displaced towards the opposite side; and that a large central swelling would, on the other hand, plainly indicate that it must be intra-peritonæal. But the following experiment, which I have made, and repeated over and over again with like results, will demonstrate, pretty conclusively, that *such diagnostic signs are entirely unreliable.*

"A small opening was made into the superior fold of the broad ligament on the left side, and at a little distance from the inferior border of the ovary, into which was inserted the tube of a syringe such as is used for anatomical injections; the parts having been secured by ligature, water was now thrown into the cellular tissue, which it entered with facility, separating the two layers of the peritonæum and spreading them out in the form of a tent. At that juncture the water passed with much more ease than elsewhere, under the peritonæal covering of the iliac fossa, raising the same off the muscle, but quickly and with but little force, filled up the whole recto-vaginal septum and opposite (right) side as high up as the brim. A vaginal examination was now made, when the finger came in contact with a large *central (retro-uterine) swelling.* The injection being next continued, the left iliac fossa rapidly became very much distended, and that of the opposite side also swollen, but to a more limited extent. The post uterine connective tissue, as high up as the junction of the cervix with the fundus at least, offered no resistance to the passage of the liquid. The lessons which this and similar experiments teach are, first, that although the lateral position of the tumor will always denote its sub-peritonæal character, yet, the fact of its being central and occupying the whole posterior part of the vagina does not, by any means, prove the contrary; and, secondly, that the position, size, or shape of the swelling—though, *if infra-peritonæal, always central* both above the brim as well as in the vagina—possesses but little, if any, value as a guide to differential diagnosis.

"There are, among others, TWO INTERESTING AND HIGHLY INSTRUCTIVE FACTS observable in connexion with the occurrence of hæmatocele: *first*, that, of all the subjects in which this peculiar disease has yet been noticed, and whose cases have been properly authenticated, married women, and especially those who have been pregnant or borne children, constitute at least four-fifths; and, *secondly*, that unmarried females, or those whose sexual organs have not been subjected to excitement, or physiological changes other than we know to attend the menstrual function, amount to a fractional portion, only, of the whole. Without dwelling on the importance of these facts as corroborative of views already set forth, it may not be amiss to notice a few reflections naturally occurring in this connexion.

"Though, after parturition, the uterine sinuses contract, and vessels imbedded in the dense stroma of that organ are supposed to resume their original size and condition, yet it by no means follows that the utero-ovarian 'thin-walled veins *without valves*'* possessed with little or no contractile power, and surrounded by loose cellular tissue, should undergo a similar change. Indeed it would seem more probable that *permanent dilatation of these veins*, more or less, *is a necessary consequence of pregnancy;* and if the ovarian vessels, in that condition, bear any analogy to those in the lower extremities, which never resume their original size, nor disappear but by obliteration, it is evident we must look here for the only true predisposing cause in all cases of sub-peritonæal hæmatocele, and which, as I before intimated, may safely be put down at 80 per cent. of the whole."

Dr. Barker, referring to the surgical treatment of hæmatocele says, "*he objects theoretically to my method—that is, puncture through the rectum, and for this reason, that the anterior and posterior walls of the rectum are always in contact, and thus the evacuation will be very incomplete,*" while "*the cavity of the vagina is much more elastic, larger, and more complete, and the evacuation through this canal will be more perfect.*" In reply, I have merely to remark, that, as the premises on which these objections are based are not strictly correct, I am unable to accept this explanation of the advantages which the vagina possesses over the rectum; because, "*the most depending part of the tumor*" *is not in contact with the posterior walls of the rectum.* Moreover, the very elasticity of the vaginal walls which he looks upon as desirable, together with the greater thickness of the intervening tissues, offers, to my mind, strong objections to choosing it as the more suitable place for puncture. As to the selection of a proper instrument, agreeing as I do with the views of Bernutz, in his late excellent treatise on the diseases of women, that "*to open largely such tumors, and to forcibly remove the clotted blood, is a most outrageous practice,*" I should always select a large-sized curved trocar. It is quite customary for writers to recommend that all palliative means should be exhausted before resorting to surgical interference in these cases; and not until the patient's life is in great danger, and rupture of the cyst and fatal extravasation into the cavity of the peritoneum become imminent, should we have recourse to such a proceeding.

I hardly think it necessary to occupy your time by adducing numerous facts which the recorded cases of hæmatocele supply, in refutation of such a pernicious doctrine: because I feel confident that the practice thus indicated, will be found to be opposed both to science and humanity. If we extract from cases which have terminated fatally after operative proceedings, those in which such interference had been *too long delayed*, and others where *undue violence* had been done to the parts *by the use of an improper instrument*, I believe we shall find but little left to deter us from resorting to timely and judicious surgical interference.

The Academy was then adjourned.

* Kölliker's Manual of Human Histology, page 257. Syd. Ed.

FOREIGN CORRESPONDENCE.

LETTER XVII.

By PROF. CHARLES A. LEE.

LUNATIC ASYLUMS.

447 Louvre Hotel, Paris, August 30, 1862.

In my last letter I gave some account of the colony of Fitz-James and the lunatic asylum connected with it, at Clermont (Oise), conducted by Dr. Labitte. I was accompanied in my visit, as I have also been to several other asylums, by Dr. Brown, of the Bloomingdale Insane Asylum, near New York, who is inspecting similar establishments in Europe, at the request of the Trustees of the Sheppard Asylum at Baltimore, Md. This institution was founded by the late Moses Sheppard, a wealthy merchant of the Society of Friends, who, several years before his death, conceived the project of testing the curability of unfavorable cases of insanity, by a more liberal expenditure of money than the friends of most asylums would reasonably permit. To this end Mr. Sheppard, having no relatives, left his whole fortune, amounting to six hundred thousand dollars, to found and maintain an experimental institution for one hundred patients. After several years of careful consideration, the Trustees of the Sheppard Asylum have commenced the construction of their building, on a plan submitted by Dr. Brown, who now studies the organization and management of European asylums, to report whatever may serve to carry out the humane purposes of the benevolent founder of this unique institution. Dr. Brown, after having visited the most celebrated asylums in Great Britain, Holland, Germany, Switzerland, and France, expresses regret at having found, thus far, but inconsiderable rewards for the commendable liberality of the Board he represents.

I have also visited the most noted institutions of this kind in England and France, and, with the exception of the agricultural colony at Clermont, I have seen nothing deserving of special commendation which is not also found in our own country. Indeed, I think, as a general rule, we are considerably in advance of the old world in the successful treatment of the insane, and our statistics will

show a larger percentage of cures than can be found in the large majority of European asylums. And it is very natural that it should be so. Americans are the most practical people in the world; they are not easily led to adopt novelties merely because they are novelties, but which have nothing else to recommend them; but they speedily introduce every improvement which is founded in reason and common sense, and which promises any practical benefits, wherever it may have originated. The unreasonable and obstinate prejudice which exists in Great Britain, against adopting anything new from foreign countries, fortunately does not exist among us, and hence we are never found lagging far behind in the race of improvement, and the march of civilization. Hence, Prof. Ackland, M.D., of Oxford, who accompanied the Prince of Wales in his recent visit to the United States, expressed surprise that American physicians should visit Europe to examine lunatic asylums, for they would find better ones at home, as at Philadelphia, under the charge of Dr. Kirkbride (and, I may also add, at Bloomingdale, under the charge of Dr. Brown), than can be found in Europe. Such I know to be the opinion of the most enlightened physicians of England, Germany, and France, who have made themselves acquainted, by personal observation, with such institutions on both sides of the Atlantic.

In England I visited, among others, the great establishments of Hanwell, Colney Hatch, Bethlehem Hospital, etc., also the private asylums of Dr. Conolly and others, but I saw nothing which is not well known and carried out in the United States. The Commissioners of Lunacy have, no doubt, effected many reforms, and corrected many evils, though they have not always sufficient power to carry out the improvements which they recommend; still public opinion, sooner or later, corrects the evil, and the public reap the benefit of their wise and practical suggestions. Such Boards are needed in our own country, and it is to be hoped that it will not be long before all our states will adopt a similar measure. There will, necessarily, be more or less clashing and friction between such boards and the trustees and managers of insane asylums, but this is incident to all supervisory bodies, and must be expected. Still, the evident benefits and improvements which they effect is a sufficient answer to the objections sometimes brought against them.

In company with Dr. Hills, of the Ohio State Lunatic Asylum, I visited the great lunatic establishment at Charenton, which is designed by the French government as the model institution of the kind in France. It is organized on a grand scale, more than six hundred thousand dollars having been recently expended in its reconstruction. It is situated on an elevated plateau, or rather terraces, protected from northerly winds by the parc of Vincennes, and commands an extensive prospect of the valley of the Marne and the Seine. The numerous sections, all furnished with galleries, courts, lawns, etc., allow of more classifications than can be found in any of our asylums. There are fountains in all the courts, and water is abundantly furnished for baths, etc., to every part of the establishment. The courts and buildings, also, are all lighted with gas, made on the premises, which is introduced into all the rooms and dormitories.

All of the rooms fronting the river command a very extensive and beautiful prospect, and the pay patients are each furnished with a separate apartment, and a place for the attendant to sleep. Both male and female wards are connected with extensive gardens and forests, where they walk a considerable part of every day. There is a farm, also, connected with the establishment, where the patients are "invited to labor," some of whom accept the invitation. But I could not learn that many of the patients were engaged either in gardening, horticulture, or agriculture; for there is not that system of organized labor which is so successfully carried out at the "colony" at Clermont. Many of the females are employed in needle work, embroidery, etc.; and there is a professor of music attached to the institution, who gives daily lessons in music; there is also a library, lecture-room, billiard-room, etc., provided for their recreation and amusement. Some are taken out in carriages to ride, music and dancing parties are held twice a week in the grand saloon, and as many of the customs of the world and French society are introduced as is thought useful or expedient. The establishment is placed under the authority of the Minister of the Interior, and is presided over by a director appointed by the Minister. There is also a "Consultive Commission," whose members are taken from the "Council of State," the "Court of Cassation," and the "Court of Accounts," appointed also by the Minister, and whose services are gratuitous.

The annual allowance for the establishment is proposed by the director, with the advice of the consultive commission, and approved by the Minister, to whom an annual report is made. The financial affairs come under the cognisance of the "Court of Accounts." Dr. Cabmeil is the Physician-in-chief, aided by several resident assistants. A chaplain also resides in the institution, who daily celebrates mass in the chapel. All the religious services are celebrated with the usual pomp of the catholic church, accompanied by the organ.

The dormitories are spacious, well lighted, and airy, and the passages warmed by iron pipes under the floor; but it struck me, as well as Dr. Hills, that there was generally a lack of proper ventilation. The day was, however, very hot and sultry, and no air stirring.

Patients are received here as boarders, and gratuitously on an order from the Minister, who has a certain number of *bourses* at his disposal, to be applied for a limited time in favor of persons having a claim on the government. There are three classes of boarders: the first, those who pay 1425 f., and upwards; the second, 1125 f.; and the third, 828 f., including washing. Certificates signed by medical men, not more than a fortnight before admission, are to be presented on behalf of lunatics previous to their admission, and certain formalities have to be complied with. Having a general ticket of admission to all the hospitals of France from the Minister of the Interior, we were freely shown through every part of the establishment, which, we have no doubt, is admirably managed. The ordinary means of physical restraints are here employed to a considerable extent, and are, in my judgment, preferable to padded rooms and complete isolation, as practised in the British institutions, as society seems indispensable to recovery. The establishment now contains about nine hundred patients.

The great Hospice *Salpetrière* is both an alms-house and a hospital, chiefly for incurable, epileptic, or lunatic female patients, and patients advanced in age. It contains 5204 beds, of which 2917 only are occupied by real patients. It is an immense establishment, consisting of forty-five distinct buildings, extending 1680 feet in length. The hospital receives, first, the *reposantes*, women who have been in its service thirty years, and who are upwards of sixty; second, indigent old women, upwards of ninety, afflicted with incurable maladies; third, insane and epileptic females. The lunatics, of whom three-fourths are considered dangerous, are kept in separate infirmaries and treated with the greatest care. I saw several hundred of them sitting at the supper-table, each with an ample allowance of wine, and a plate of ripe plums and apricots, besides bread, etc. It was a delightful sight to see the cheerfulness of the old ladies, and hear their merry chat as they partook of their evening meal.

The *Bicêtre* is situated on lofty ground, differing in this respect from the Salpetrière, and enjoys a more salubrious air than most of the Parisian hospitals. It is an asylum for indigent old men and male lunatics, and receives about two thousand patients. It presents a square of nine hundred feet on each side, and contains three courts. The indigent and infirm old men occupy the greater part of the building. They have no private rooms, but there are large rooms with workshops and dormitories, as also several gar-

dens and court-yards for exercise. They are obliged to work three hours a day at their respective trades, or other occupations, and receive in return a share of the profits; the rest goes towards defraying the expenses of the establishment. The daily allowance to the indigent is a portion of soup, a pound and a quarter of bread, four ounces of meat for dinner, vegetables or cheese at night, and a quarter of a pint of wine. The average daily cost of each is nine sous (cents), and the total annual expense about nine hundred thousand francs. The number of lunatics, idiots, and epileptics is about nine hundred, who have the same allowance as paupers, except a larger allowance of bread. Physical restraint, by strait jackets, etc., is very common. Generally, however, the treatment is very mild, and daily employment is given on a model farm and bleaching-ground, where there are also sties for breeding swine of superior breeds. This farm not only supplies the establishment, but produces sufficient to partly supply the other Parisian hospitals. There are various kinds of schools in the establishment for lunatics of all ages. Instrumental concerts are often given by the patients. Voisin, Delasiuave, and Moreau are the physicians having charge of the lunatics.

There are also numerous private lunatic asylums in the neighborhood of Paris, the most celebrated being that founded by Esquirol at Ivry, Dr. Marcet, of the Bicêtre, being resident physician; the *Maison de Santé du Chateau, Sainte-James, près Paris*, and the *Maison de Santé* of Dr. Blanche, at Passy. The establishment of *Sainte-James* is near the Bois de Boulogne, and is carried on by Dr. Casimer Pinel, the nephew of the celebrated Pinel. It is a very extensive old chateau, built in the reign of Louis XV., and in the style of that age, and was occupied during the reign of Louis Philippe by M. Thiers, his minister, the distinguished historian. The grounds, which occupy several acres, are handsomely ornamented with flowers, shrubs, and trees, artificial lawns, grottoes, and bodies of water, etc. There is a large and productive kitchen-garden, and a variety of fruit trees. The walks are pleasant and well shaded, and there is a commodious billiard-room excavated from a solid rock. There are several buildings appropriated to the patients who belong to the wealthier classes, and pay from seven to twelve hundred dollars annually. Nearly all have their own servants. The two sexes occupy distinct premises. The attendant sometimes occupies the same room with the patient, but more frequently an adjoining one, separated by lattice-work. The fire and lights are also placed in the servant's room, and are inaccessible. The main building seemed to me very poorly adapted to the purpose of an insane asylum, many of the rooms being small, and not being well lighted or ventilated. The Doctor is a member of the Legion of Honor, and an author of distinction. He very politely gave me several of his works on insanity. He is a great advocate for the use of prolonged baths, and long continued dripping of cold water on the head in certain cases of insanity, and has written a treatise on the subject. He has also written a work on the "Isolation of the Insane," which he deems advisable in a large majority of cases; not at home, but in a public or private asylum, and indispensable for the poorer classes. He insists on the great importance of resorting to it at as early a period as possible, and believes that the incurable cases originate from a neglect of isolation in the beginning of the disease.

The Doctor resorts to the usual modes of physical restraint in all violent cases, and where the patients are inclined to injure themselves or others. He is about sixty, of affable and agreeable manners, and enthusiastic in his specialty. He numbers about forty patients. The private institution of Dr. Blanche, at Passy, is also located in an old chateau of the age of Louis XV., built by Prince Carignan, and occupied by his descendants for many generations. During the French Revolution it was occupied by the Princess Lamballe, who was seized in this very house and dragged before the Revolutionary Tribunal, to be brutally murdered by the mob before she could reach the guillotine. Extensive additions have, however, been made by Dr. Blanche, so that it is now tolerably well adapted to the purposes of such an establishment. The premises occupy several acres, which are well laid out in walks, pastures, lawns, etc., and planted with ornamental trees and shrubbery. Each patient has his own attendant and a separate apartment. Each patient pays, on an average, about one thousand dollars annually, some more, some less. Physical restraints are freely used, as preferable to padded rooms. Dr. Blanche does not believe in isolation, nor in prolonged baths, nor water drippings on the head. There may, possibly, exist some rivalry between him and Dr. Pinel, for they are rather antagonistic on many points. The Doctor spoke highly of Arnot's water-bed for paralysed cases. To the question, why general palsy was more frequent than formerly, Dr. Blanche replied that people lived faster than they used to, used up their nervous agency sooner than they formerly did, which I conceive is the true explanation. He said that domestic unhappiness was a very frequent cause of insanity; that there were few happy marriages in France; that those in Paris could easily be counted; that most of those who lived together were not man and wife, etc. I hope he is mistaken.

Dr. Blanche showed Dr. Brown and myself every part of his establishment, and explained fully his views in regard to the management of the insane. He has about eighty patients, and his terms, as will be seen, are about the same as those of Dr. Pinel. This must suffice for the public and private lunatic asylums of France. The subject is far too vast to be treated satisfactorily within the limits I have allotted myself; but there are other topics, at least as interesting, which demand our notice, and which will receive attention in future communications.

American Medical Times.

SATURDAY, DECEMBER 6, 1862.

GARIBALDI'S WOUNDS.

The recent misadventure by which the life of the Italian patriot Garibaldi has been jeoparded, has gradually assumed a professional aspect of remarkable interest. No less than four nationalities have been represented in the consultation over his wounds. From the conflicting accounts which have been published, we glean the following facts:—

Garibaldi received a gunshot wound of the ankle at the battle which resulted in his capture. The ball opened the joint, fracturing the internal malleolus. The question of the presence of the ball in the wound divided the eminent Italian surgeons in attendance, the majority inclining to the opinion that it was present. No efforts were made to remove it, and the health of the patient soon became critical. They put forth the following opinion of the condition of the patient:—

"From the general course of the illness, and from all our foregoing observations, we think we may anticipate a favorable success, notwithstanding the degree of anchylosis which may manifest itself; but we are still of opinion that the wound is serious—1, because the important articulation of the foot with the leg is open, and the internal ankle is fractured; 2, because the presence of the bullet is not disproved; 3, on account of the arthritic disposition of the sufferer—all circumstances which might give rise to morbid complications of such a nature as to prolong and even to

aggravate the complaint. As to the cure, we deem it expedient to persevere in the treatment hitherto followed."

About this time an English Society sympathizing with the sufferer, determined to despatch a surgeon to ascertain exactly what was the condition of the wound, and relieve their suspense. Regardless of all professional etiquette, being invited neither by the patient nor his surgeons, the surgeon, a MR. PARTRIDGE, accepted the proffered mission (and a fee of $3000), and subsequently published the following statement:—

"The accident may be described, shortly, as a transverse compound fracture of the right internal malleolus (ankle bone), produced by a rifle shot, which, though it opened the joint by a small aperture, did not enter it nor lodge itself in any other part of the limb. The outer ankle bone remains uninjured, nor does the astragalus (the great pulley-like bone of the foot, which sustains the leg) appear to have been injured; the most careful examinations, made immediately after the accident and since, have led to the conclusion that no other bone except the tibia (or greater bone of the leg) was implicated in the injury. At first severe inflammation, swelling, and excessive pain, followed upon the infliction of the wound; but these were subdued by cold applications, cataplasms, leeches, and rest, so that now the ankle and surrounding parts present nearly their natural size and form, the foot being almost at a right angle with the leg, and otherwise in excellent position. The wound, the circumference of which (on its superficial aspect) is rather larger than that of half a franc, looks well, and discharges healthy matter, mingled with molecular fragments of exfoliating bone, which are rarely larger than grains of sand. The present unswollen state of the ankle and of the parts around it permits of an examination, which has confirmed the assurance given by other circumstances, that the bullet did not enter the joint, nor effect a lodgment elsewhere. * * * * My opinion is that (bearing in mind his habitually abstemious habits), if mental as well as bodily repose are steadily enforced, if the injured limb be kept at perfect rest, if the general health and strength be sustained by suitable nourishments (and, if need be, by stimulants), by well aired, well kept, and quiet rooms, and, lastly, by a continued supply of those comforts necessary to his present condition, the general will, with time (certainly some months) and care, have a good, useful foot, though the ankle-joint may become stiff, or, at the best, be only partially movable.

Bearing date of Spezzia, Oct. 31, is the following card, signed by PIROGOFF, we presume the distinguished Russian Surgeon:—

The examination of General Garibaldi's wounded foot has furnished the following results:—

1. The articulation of the foot is opened by the ball on the internal side.
2. The two malleoles, together with the internal portion of the articulation, are tumefied.
3. As far as we can judge by external exploration, the ball will be found towards the external part of the articulation, fixed in the bone.
4. The suppuration is sufficiently good, and not abundant.
5. The foot is slightly turned inwards.
6. The distance between the two malleoles is greater on the wounded side by one and a quarter to one and a half than on the uninjured side.
7. The exploration of the wound, either with the finger or with instruments, is only indispensable when the certainty is reached that the ball has become mobile, and has neared the surface; such exploration should be followed immediately by the extraction of the ball.
8. The general health of the patient is excellent.
9. The expectative method—*i.e.* patience—is the one and only method to be followed in the present moment. It must be changed when the quality of the pus, the detachment of splinters, or the formation of an abscess, prove the evident necessity of the extraction of the ball.
10. The method of dressing the wound by the attending surgeon leaves nothing to be desired.
11. It is indispensable that the patient be kept in a spacious and well aired chamber, and that he pass the winter in a warm and dry climate.

Finally, we have added to the consultation a representative of French surgery in the person of the eminent surgeon NELATON. He visited Italy by invitation of the patient. The report which he presented contains the following opinions:—

"I think that the ball lies within the wound, and that the probe strikes against it when introduced about one inch into the part. I must say that my impression, as to to the state of the wound, was very favorable when the limb was freed from dressings. The patient is not in danger at present; the pulse is good, the skin cool, the appetite sufficient, sleep satisfactory, and the aspect of the patient excellent. As to treatment, I think that the opening should be gradually widened for some days towards the foreign body, by means of dilating substances. At the end of five or six days the wound will be large enough to admit of extraction with the ball-forceps. It is preferable to extract thus gradually than by immediate means, which, however, would be quite practicable. Summary measures of the latter kind would present some difficulties; they would give rise to much pain and fever. They are, moreover, not imperiously required, as the patient's general health is every day improving."

We have here a grave consultation over a case admitting of the most rigid inspection, composed of representatives of Italian, English, French, and Russian surgery. It is stated that at the last consultation there were no less than seventeen surgeons present. The practical points reviewed are of great interest to the American surgeon, and may be briefly summed up as follows:—Is the ball present or not, in an open gunshot wound which the probe can readily explore to its extreme limits? If present, is the ball to be removed at once, or by gradual means? Such is the question presented practically to the best surgeons of Europe and about which, there is a difference of opinion. The conclusion of the consultation reveals English surgery pitted in diagnosis against continental surgery. The weight of evidence, giving due prominence to the reputation of the consultants, is largely in favor of the presence of the ball in the wound. English surgery, never expert in diagnosis, will doubtless have to yield this point. It would be gratifying to know what was the method of examining the wound. The patient is said to have suffered great agony during the examination; from which it is proper to infer that no anæsthetic was administered, unless there were strong objections. This was a singular omission, in a case of so much doubt, of an aid which would have greatly facilitated the exploration! Finally, shall a ball, lodged in an open wound involving a joint, be removed forcibly when "quite practicable," or be allowed to escape by the process of suppuration? The consultants in this case decided to dilate the wound gradually, and allow the ball to escape. The argument in favor of this method is, that summary measures would give rise to pain and fever. An Italian writer, in criticising this decision, states very justly that the first precept in surgery, in such cases, is to extract the projectile, as its presence may lead to profuse suppuration or purulent absorption. It would certainly be

a novel feature in American surgery to allow a ball to remain in the ankle-joint when the removal was "quite practicable," and the only obstacle was the danger of giving pain.

THE WEEK.

We have already noticed the establishment of a Directory of hospitals by the Sanitary Commission. Through the efforts of the indefatigable Secretary, Mr. Olmsted, this Directory has already been brought into complete working order, and will prove one of the most important and useful branches of the service of the Commission. The following circular explains the nature of this Directory:—

The Sanitary Commission have established an office of information in regard to patients in the Hospitals of the District of Columbia, and of Frederick City, Maryland. By a reference to books, which are corrected daily, an answer can, under ordinary circumstances, be given by return mail to the following questions: 1st. Is —— - —— [giving name and regiment] at present in the hospitals of the District or of Frederick City? 2d. If so, what is his proper address? 3d. What is the name of the Surgeon or Chaplain of the hospital? 4th. If not in hospital at present, has he recently been in hospital? 5th. If so, did he die in hospital, and at what date? 6th. If recently discharged from hospital, was he discharged from service? 7th. If not, what were his orders on leaving? The Commission is prepared also to furnish more specific information as to the condition of any patient in the District hospitals, within twenty-four hours after a request to do so, from an officer of any of its corresponding societies. The office of the Directory will be open daily from 8 o'clock A.M. to 8 o'clock P.M., and accessible in urgent cases at any hour of the night. The number of patients in these hospitals is about 25,000. If found to be practicable, the duty here undertaken locally by the Commission will be extended to include all the general hospitals in the country.

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A London medical contemporary sneeringly remarks that American army surgeons who attempt to gain a livelihood by practice, after peace is restored, will quickly be reduced to the condition of the Lancashire operatives. This remark has significance only to an English mind, which cannot conceive of a country where the honest, frugal, and industrious citizen never knows want. And yet it ought to be apparent, even to Englishmen, that a country capable of carrying on the most gigantic war of modern times, and at the same time of charitably relieving their starving countrymen by shiploads of food, cannot have a class of necessary paupers.

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We desire to call the attention of the Surgeons in charge of military hospitals to the Diet Table for the General Hospitals, U. S. Army, which has been prepared by a commission appointed by the Surgeon-General. It is important that a uniform diet table should be adopted in all hospitals, but before any particular form is selected, that recommended by the Commission is submitted for trial.

Miss Nightingale.—We regret to learn that there is only the very slightest foundation for the report of Miss Nightingale's restoration to health. She is able to remove from one place of residence to another—a very few miles—once a year, but she is scarcely able to leave her bed in the intervals, and quite unable to struggle with the flood of correspondence and applications of all kinds which the report of her partial recovery has brought upon her.—*Brit. Med. Jour.*

Correspondence.

AN IMPOSTOR AMONG MEDICAL MEN.

[To the Editor of the American Medical Times.]

Sir:—I have just learned of a successful deception practised upon several gentlemen of the Profession in New York and Philadelphia, personally unknown to me, under the assumption of my name. As in these instances sums of money have, on various pretexts, been obtained, I beg that any one upon whom the imposter referred to may call, will do me the justice to procure his arrest.

Yours, etc.

Horatio R. Storer, M.D.

Boston, Nov. 27, 1862.

Army Medical Intelligence.

DIET TABLE FOR GENERAL HOSPITALS,

United States Army.

ARTICLES COMPOSING THE DIFFERENT DIETS FOR A DAY, AVOIRDUPOIS WEIGHT.

FULL DIET.			HALF DIET.		
Meat	oz.	16	Meat	oz.	8
Bread	oz.	18	Bread	oz.	16
Potatoes	oz.	8	Potatoes	oz.	6
Other Vegetables	oz.	8	Other Vegetables	oz.	6
Rice, Hominy, or Indian Meal	oz.	1.60	Rice, Hominy, or Indian Meal	oz.	1.60
Salt	gill.	0 16	Salt	gill.	0 16
Coffee	oz.	0.80	Coffee	oz.	0.80
Tea	oz.	0 12	Tea	oz.	0.12
Sugar	oz.	2 40	Sugar	oz.	2.40
Milk	oz.	8	Milk	oz.	8
Butter	oz.	1	Butter	oz.	1
Flour	oz.	0 25	Flour	oz.	0 25
Molasses	gill.	0 32	Molasses	gill.	0.32
Vinegar	gill.	0.32	Vinegar	gill.	0.32
TUESDAY, *in lieu of Fresh Meat:*					
Pork	oz.	8			
Beans	gill.	0 64			

CHICKEN DIET.			LOW DIET.		
Fowl	oz.	12	Meat	oz.	8
Bread	oz.	18	Bread	oz	14
Salt	gill.	0.16	Salt	gill.	0.16
Tea	oz.	0 24	Tea	oz.	0.24
Sugar	oz	2.40	Sugar	oz.	2 40
Milk	oz	3	Milk	oz.	8
Butter	oz.	1	Butter	oz.	1
			Rice, Farina, Corn Starch, or Bread, made into Pudding	oz.	2

MILK DIET.			BEEF-TEA DIET.		
Bread	oz.	14	Beef (without bone)	oz.	8
Rice	oz	2	Bread	oz.	12
Milk	pt.	3	Salt	gill.	0.32
Sugar	oz.	1	Tea	oz.	0.24
			Sugar	oz.	2
			Milk	oz.	4

EXTRA DIETS AND DRINKS.

Beef Steak.	Sugar, brown.	Lemons.
" Essence.	Barley.	Fruits.
" Extract.	Cracked Wheat.	Ice.
Mutton Chop.	Gruel, Corn meal.	Barley-water.
" Broth.	" Oat Meal.	Rice water.
Veal Cutlet.	Farina.	Jelly-water.
Ham, broiled.	Corn Starch	Lemonade.
Poultry.	Tapioca.	Wine Whey.
Game.	Crackers.	Brandy.
Eggs.	Toast.	Whiskey.
Fish.	Chocolate.	Wine, Sherry.
Oysters, raw.	Cocoa.	"
" stewed.	Blanc Mange.	Porter.
Clam Soup.	Wine Jelly.	Ale.
Vegetables (special).	Custard.	Cider.
Milk.	Oranges.	Milk Punch.
Sugar, white.		

FULL DIET.

SUNDAY.

Breakfast.	Coffee	pt.	1
	Bread	oz.	6
	Butter	oz.	½
	Hominy, boiled	oz.	2
	Molasses	gill.	0.32
Dinner.	Roast Beef	oz	16
	Potatoes	oz.	8
	Other Vegetables	oz.	8
	Bread	oz.	6
	Rice Pudding		
Tea.	Tea	pt.	1
	Bread or Crackers	oz.	6
	Cheese	oz.	3

MONDAY.

Breakfast.	Coffee	pt.	1
	Bread	oz.	6
	Butter	oz.	½
	Cold Meat	oz.	4
Dinner.	Beef Soup	pt.	1½
	" " Meat	oz.	12
	Bread	oz.	6
	Potatoes	oz.	8
	Other Vegetables	oz.	8
Tea.	Tea	pt	1
	Bread	oz	6
	Butter	oz.	½

TUESDAY.

Breakfast.	Coffee	pt.	1
	Bread	oz	6
	Butter	oz.	½
	Meat Hash, with Vegetables	oz.	8
Dinner.	Pork | Baked	oz.	8
	Beans | or in Soup	gill.	0.64
	Potatoes	oz	8
	Other Vegetables	oz.	8
	Bread	oz.	6
	Indian Pudding		
Tea.	Tea	pt.	1
	Bread	oz.	6
	Butter	oz.	½
	Fruit, stewed	oz.	4

WEDNESDAY.

Breakfast.	Coffee	pt.	1
	Bread	oz	6
	Butter	oz.	½
	Indian Meal, boiled	oz.	2
	Molasses	gill.	0.32
Dinner.	Beef, recently corned, or Ham, boiled	oz.	16
	Potatoes	oz.	8
	Other Vegetables	oz.	8
	Bread	oz.	6
	Pickles	oz.	1
Tea.	Tea	pt.	1
	Bread	oz.	6
	Butter	oz	½

THURSDAY.

Breakfast.	Coffee	pt.	1
	Bread	oz	6
	Butter	oz	½
	Meat Hash, with Vegetables	oz.	8
Dinner.	Semi-stewed Beef or Mutton	oz	12
	Do. do. Soup	pt.	1
	Potatoes	oz	8
	Other Vegetables	oz	8
	Bread	oz	6
Tea.	Tea	pt.	1
	Bread or Crackers	oz	6
	Cheese	oz.	3

FRIDAY.

Breakfast.	Coffee	pt	1
	Bread	oz.	6
	Butter	oz.	½
	Fish, fresh or salt	oz.	8
Dinner.	Cod-fish, in Hash	oz	8
	" with Potatoes	oz	12
	Beets or Turnips	oz.	8
	Bread	oz.	6
	Bread Pudding		
Tea.	Tea	pt	1
	Bread	oz	6
	Butter	oz.	½

SATURDAY.

Breakfast.	Coffee	pt.	1
	Bread	oz	6
	Butter	oz.	½
	Hominy, boiled	oz	2
	Molasses	gill.	0.32
Dinner.	Semi-stewed Beef or Mutton	oz.	12
	Do. do. Soup	pt.	1
	Potatoes	oz	8
	Other Vegetables	oz	8
	Bread	oz.	6
Tea.	Tea	pt.	1
	Bread	oz.	6
	Butter	oz.	½
	Fruit, stewed	oz.	4

HALF DIET.

SUNDAY.

Breakfast.	Coffee	pt.	1
	Bread	oz.	6
	Butter	oz.	½
	Indian Meal, boiled	oz	2
	Molasses	gill.	0.32
Dinner.	Beef Broth	pt.	1
	" " Meat	oz.	8
	Bread	oz	4
	Potatoes	oz.	6
	Other Vegetables	oz.	6
	Rice Pudding.		
Tea.	Tea	pt.	1
	Bread	oz.	6
	Butter	oz.	½

MONDAY.

Breakfast.	Coffee	pt.	1
	Bread	oz.	6
	Butter	oz.	½
Dinner.	Beef Soup	pt.	1
	" " Meat	oz.	8
	Bread	oz.	4
	Potatoes	oz.	6
	Other Vegetables.	oz.	6
Tea.	Tea	pt.	1
	Bread	oz	6
	Butter	oz.	½

TUESDAY.

Breakfast.	Coffee	pt	1
	Bread	oz.	6
	Butter	oz.	½
	Hominy, boiled	oz.	2
	Molasses	gill.	0.32
Dinner.	Mutton or Beef broth	pt.	1
	" " Meat	oz.	8
	Bread	oz.	4
	Potatoes	oz.	6
	Other Vegetables	oz.	6
	Indian Pudding.		
Tea.	Tea	pt.	1
	Bread	oz.	6
	Butter	oz.	½

WEDNESDAY.

Breakfast.	Coffee	pt.	1
	Bread	oz.	6
	Butter	oz.	½
Dinner.	Beef Soup	pt.	1
	" " Meat	oz	8
	Bread	oz.	4
	Potatoes	oz.	6
	Other Vegetables.	oz.	6
Tea.	Tea	pt.	1
	Bread	oz.	6
	Butter	oz.	½

THURSDAY.

Breakfast.	Coffee	pt.	1
	Bread	oz	6
	Butter	oz.	½
	Indian Meal, boiled	oz	2
	Molasses	gill.	0.32
Dinner.	Beef or Mutton Broth	pt.	1
	" " Meat	oz.	8
	Bread	oz.	4
	Potatoes	oz.	6
	Other Vegetables.	oz.	6
Tea.	Tea	pt.	1
	Bread	oz.	6
	Butter	oz.	½

FRIDAY.

Breakfast.	Coffee	pt.	1
	Bread	oz.	6
	Butter	oz.	½
Dinner.	Cod-fish Hash, with Potatoes	oz.	8
	Bread	oz.	4
	Vegetables	oz.	6
	Bread Pudding.		
Tea.	Tea	pt.	1
	Bread	oz	6
	Butter	oz.	½

SATURDAY.

Breakfast.	Coffee	pt.	1
	Bread	oz.	6
	Butter	oz.	½
	Hominy, boiled	oz	2
	Molasses	gill.	0.32
Dinner.	Beef Soup	pt.	1
	" " Meat	oz.	8
	Bread	oz.	4
	Potatoes	oz.	6
	Other Vegetables	oz.	6
Tea.	Tea	pt.	1
	Bread	oz.	6
	Butter	oz.	½

CHICKEN DIET.

Breakfast.	Tea	pt.	1
	Bread	oz.	6
	Butter	oz.	½
Dinner.	Chicken	oz.	1½
	Or Chicken Soup	pt.	6
	Bread	oz.	
Tea.	Tea	pt.	1
	Bread	oz.	6
	Butter	oz.	½

LOW DIET.

Breakfast.	Tea	pt.	1
	Bread	oz.	5
	Butter	oz.	½
Dinner.	Beef Tea, or Mutton or Chicken Broth	pt.	1
	Bread	oz.	4
	Rice, Farina, Corn Starch, or Bread in Pudding	oz.	2
Tea.	Tea	pt.	1
	Bread	oz.	5
	Butter	oz.	½

MILK DIET.

Brfst.	Milk	pt.	1
	Bread	oz.	6
Dinner.	Rice	oz.	2
	Milk	pt.	1
	Bread	oz.	4
	Sugar	oz.	1
Tea.	Milk	pt.	1
	Bread	oz.	4

BEEF-TEA DIET.

Tea.	Tea	pt.	1
	Bread	oz.	4
Dinner.	Beef Tea	oz.	12
	Bread	oz.	4

NOTE.—Medical Officers who receive this Diet Table are directed to adopt it immediately in the hospitals under their charge, and to comply strictly and carefully with its provisions for thirty days, keeping during that period an accurate account of expenditures from the Hospital Fund. At the end of that time they will report the results of this experimental trial, its effects upon the sick and upon the Hospital Fund, and will make such suggestions as they may deem appropriate, the object being to test the practical operation of the Diet Table, before adopting it as the standard for the General Hospitals.

It is recommended that the diets be prepared according to receipts in the Stewards' Manual.

WM. A. HAMMOND, Surgeon General U.S A.

SURGEON GENERAL'S OFFICE, October 28, 1862.

Medical News.

DISEASES OF THE HEART IN AUSTRALIA.—Inflammation of the pericardium is more common in the colony than in England, and the deaths are more numerous. Thus about 1 out of every 359 deaths which ensued in Melbourne during twelve months was from this disease; while in London it amounted to only 1 out of every 532 of the deaths, and in England to only 1 out of every 889. Aneurism, again, is both more frequent and more fatal in the colony than in England. The deaths in Melbourne in twelve months from this disease were 26 out of 3,593 deaths from all causes—about 1 in 138; while in London the number was only 68 out of 59.103 of the deaths from all causes—about 1 in 869; while in England the deaths were 321 out of 419,865 of the deaths from all causes—about 1 in 1,349.—*Medical Record.*

METEOROLOGY AND NECROLOGY OF THE WEEK IN THE CITY AND COUNTY OF NEW YORK.

Abstract of the Official Report.

From the 24th day of November to the 1st day of December, 1862.

Deaths.—Men, 82; women, 74; boys, 100; girls, 96; total, 352. Adults, 156; children, 196; males, 182; females, 170; colored, 4. Infants under two years of age, 127. Children born of native parents, 26; foreign, 180.

Among the causes of death we notice:—Apoplexy, 3; infantile convulsions, 20; croup, 23; diphtheria, 19; scarlet fever, 10; typhus and typhoid fevers, 6; consumption, 70; small-pox, 3; measles, 3; dropsy of head, 9; infantile marasmus, 18; cholera infantum, 1; inflammation of brain, 5; of bowels, 7; of lungs, 30; bronchitis, 3; congestion of brain, 12; of lungs, 7; erysipelas, 3; diarrhœa and dysentery, 11. 186 deaths occurred from acute diseases, and 28 from violent causes. 225 were native, and 127 foreign; of whom 89 came from Ireland; 35 died in the City Charities; of whom 6 were in Bellevue Hospital, and 1 died in the Immigrant Institution.

Abstract of the Atmospherical Record of the Eastern Dispensary, kept in the Market Building, No. 57 Essex street, New York.

Nov.	Barometer.		Temperature.			Difference of dry and wet bulb. Thrm.		Wind.	Mean amount of cloud.	Humidity. Saturation, 1000
1862	Mean height.	Daily range.	Mean	Min.	Max.	Mean	Max.			
	In.	In.	°	°	°	°	°			
23rd.	29 90	.30	33	28	35	6	8	N.W.	4	609
24th.	30.10	.15	38	26	38	7	10	NW to SW	0	560
25th.	29 91	.20	42	33	50	6	10	S.W to S.E	5	630
26th.	29.68	.34	38	34	42	2	2⅛	N.E to S.E	9 8	860
27th.	29 84	.06	36	33	40	7	10	N.W.	2	564
28th.	29 71	.12	34	34	44	5	8	NW to SW	3	680
29th.	29.73	.07	40	36	43	2	3	N.E to S.E	10	862
30th.	29 98	.16	39	33	42	6	10	S.W.	4	620

REMARKS.—23d, Very light snow morning, variable afternoon, clear night, wind fresh all day. 24th, Fine day. 25th, Hazy early A.M., clear morning: cloudy P.M., rain commenced at 5¼. 26th, Fog early, cloudy all day, a little sunshine at noon; rain evening. 27th, S.W. early A.M., fine day, fresh wind nearly all day, variable sky P.M. 28th, Clear A.M., variable P.M. 29th, Fog early, light rain commenced at 11 A.M. and then continued through the day. 30th, Fine A.M., hazy P.M., cloudy at night. Rain for the week half an inch.

SPECIAL NOTICES.

SYDENHAM SOCIETY.—*The subscribers are notified that the Plates of* 1861 *are received by the Secretary,* DR. HEYWOOD.

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